Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GERALD PETER FOOX, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-13-2681-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Office"

Amount in Dispute: $278.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… The following is the carrier's statement with respect to this dispute of 2/15/13.

The requestor billed code 99455-V5-WP for determining MMI/IR of the claimant. Rule 133.204(j)(C)(3)12 states one of the "V" modifiers corresponding to the applicable office should be billed, which the requestor did do. The requestor also used the DRE method to arrive at the level of impairment. The reimbursement amount for 99455-V5 given the requestor's zip code is $221.29. The DRE method is reimbursement at $150.00. These two amounts together are $371.29. The requestor, though, argues the impairment reimbursement should be $350.00 for range of motion. Texas Mutual does not agree."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2013	CPT Code 99455-V5-WP	$278.71	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEUDLE ADJUSTMENT
   - 725 – APPROVED NON NETWORK PROVIDER FOR TEXAS STAR NETWORK CLAIMANT PER RULE 1305.153(C)

- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, TI WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §134.204 states (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:, (3) The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit. (4) The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

   Review of submitted documentation provided by the requestor finds no additional reimbursement is recommended for Maximum Medical Improvement (MMI) and Impairment Rating to one body area using diagnosis related estimate (DRE) method.

   The total MAR for CPT Code 99455-V5-WP is $371.29.

   The respondent issued payment in the amount of $371.29. Based upon the documentation submitted, no additional reimbursement is recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/9/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee***

Dispute Resolution Findings and Decision together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.